

## Peer Review File

Article information: <https://dx.doi.org/10.21037/atm-23-1509>

Comment 1: ERAS only works for breast reconstruction if the patients have the impression that surgery, especially autologous reconstruction, is easy. So the idea should be to give as much information as possible in the beginning and then perform safe surgery. The patients are too misinformed and are afraid. ERAS has to overcome this psychological hurdle.

Reply 1: The authors thank you for this excellent summary of our findings regarding the role of managing patient expectations in ERAS. We are in agreement.

Changes in the text: The authors have incorporated this summary into the paper “These findings emphasize the importance of patient expectation management as part of an enhanced recovery protocol. The psychological component of patient expectations and concerns must be considered, as it can constitute a barrier to optimal recovery. It appears that this aspect is easily addressed by timely and adequate patient education.” (Page 7)

Comment 2: Preoperative analgesia is not mandatory. it should be discussed more specifically. In Europe it is not really used. Preinterventional nerve blocks make it complicated are not needed. intraoperative abdominal blocks are far easier and work better.

Reply 2: The authors concur that preoperative analgesia is not mandatory but hesitate to dismiss it outright due to potential benefits in terms of reduced opioid use and shorter length of stay.

Although pre-interventional nerve blocks are not currently part of ERAS protocols, we have had excellent success with employment in our own institutional protocols, and would argue that they have demonstrable benefit. Both pre-operative and intra-operative blocks are undoubtedly valuable tools, with superiority of one over the other not fully elucidated

Changes in text: Clarifying additions

“Although preoperative analgesia is not an essential component of ERAS protocols, it appears to be widely used. The potential benefits regarding reduction in opioid use and shorter hospital stays indicate it may be premature to dismiss it entirely.” (Page 10)

“The literature reflects variation in the type of blocks administered, both pre and intraoperatively. This to some extent appears to be a function of surgeon/institutional preference. The authors’ preference is for pre-operative blocks, but much of the literature reports equivalent success with employment intraoperatively.” (Page 13)

Comment 3: Fast surgery (breast reconstruction is no educational surgery!) and normothermia, foley removal directly after surgery are the key to early mobilization and pain free healing.

Reply 3: The authors agree that attaining the maximal surgical speed and efficiency possible with these protocols is likely unrealistic in an academic institution. But, training is a requirement. We perform these procedures in an educational setting while working towards the whatever increased efficiency is possible.

Likewise, the authors agree that maintaining normothermia and early foley removal are vital to quick and complication/pain-free patient recovery.

Changes to text: We have incorporated comments summarizing the above  
“Interestingly, the importance of maintaining normothermia was specifically mentioned in less than 20% of the captured studies.” (Page 12)

“Although optimal efficiency may be difficult to achieve while teaching, in the authors’ experience training is not incompatible with protocols for operative-time reduction.” (Page 15)

“As emphasized by Astanahe et. al, early foley removal and early ambulation are key factors in achieving these goals. (34)” (Page 17)

Comment 4: Abstinence from caffeine is purely anecdotal. Neither the patient nor the surgeon has to abstain.

Reply 4: The authors appreciate the reviewer’s emphasis on this and agree that there is no sound basis in the literature for this persistent belief.

Changes to text: Added citation for the views of Dr. Acland  
“The controversy surrounding caffeine consumption and surgery appears to be a long standing, if unfounded one. Its effect on the microsurgeon was addressed by Dr. Acland decades ago in his *Practice Manual for Microvascular Surgery*. (83) He notes that for the surgeon, abrupt changes in caffeine consumption are more deleterious than maintaining an established habit. Most research indicates that this principle is likely equally applicable to patients and their recovery” (Page 18)

Comment 5: We safely navigate our (European) patients with intraop. blocks, opioids if necessary on the day of surgery, removal of foley cath directly after surgery, mobilization after surgery, and beginning with day 1 only with ibuprofen and paracetamol/acteaminophen. no flap monitoring. Only LMW heparin, nothing else, no monitoring. keep it simple.

Reply 5: The authors appreciate the reviewer’s insight and are in agreement. The goal is to keep things as simple and safe as possible. Our protocol involves discharge on postoperative day one with no flap monitoring. This has resulted in no adverse

outcomes in our experience to date.

**Changes to text: Added Emphasis**

“Of note, the authors’ experience moving towards discharge on postoperative day one for all autologous reconstructions and without flap monitoring is yet to see microvascular compromise or flap failure in the outpatient setting. Akin to this, it may be reasonable to discontinue monitoring, after 24 hours, during inpatient stay. Complete discontinuation is controversial, but many authors note conversion to every-four or every-eight hour checks.” (Page 22).